OneAmerica® Financial

Plan for care

Written plan of care for Date: (MM) (DD) (YYYY)

Family / Friends to notify immediately

Attorney / CPA / Trustee / Other

Banker / Financial Advisor(s)

What experience do you have with any family or friends who need care?

Do you believe you could live a long life and need help from others for your care? ☐ Yes ☐ No

If no, please explain.

You may never need care, but if you did, how would it affect your family? (Physically, emotionally, financially)

Any other concerns?

If you ever need care, would you like to:

- ☐ Preserve your ability to choose
- ☐ Decide now where you will receive care
- ☐ Defer this decision until later
- ☐ Defer this decision to someone else

  Who? _____

Who do you want to physically provide your care?

- ☐ Your spouse
- ☐ Your child
- ☐ A professional caregiver
- ☐ Other: _____

Where would you want to receive care?

- ☐ Your home
- ☐ Your child's home
- ☐ Assisted living facility
- ☐ Nursing home facility
- ☐ Other: _____

Who do you want to be responsible for coordinating your care?

- ☐ Your spouse
- ☐ Your children
- ☐ A professional care coordination service
- ☐ Other: _____

I-36333 07/03/26

How will you generate the income every month to pay for your care needs?

1. Which asset first? _____

2. Which asset next? _____

3. Which asset next? _____

4. Which asset next? _____

5. Which asset next? _____

6. Children/Family will pay for it. _____

What other planning have you done?

- ☐ Living will
- ☐ Health care directive
- ☐ Power of attorney
- ☐ Trust
- ☐ Other: _____

My policy information

Long-Term Care

Carrier: Name, Address, Phone number

Policy number, Primary Beneficiary(ies)

Contingent Beneficiary(ies) — if applicable

Life policies

Carrier: Name, Address, Phone number

Policy number, Primary Beneficiary(ies)

Contingent Beneficiary(ies) — if applicable

Annuity

Carrier: Name, Address, Phone number

Policy number, Primary Beneficiary(ies)

Contingent Beneficiary(ies) — if applicable

Printed name & relationship

Date: *(MM)* *(DD)* *(YYYY)*

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